STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155152	A. BUILDING 01 B. WING	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTICELLO ASSISTED LIVING AND HEALTHCARE	1120 N MAIN ST MONTICELLO, IN 47960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 02/28/13 Facility Number: 000072 Provider Number: 155152 AIM Number: 100287440 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Monticello Assisted Living and Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This fully sprinklered facility consists of a one story building of Type V (000) construction with a partial basement and a two story building determined to be Type V (111) construction. The facility was surveyed as two buildings due to different	K010000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	construction Types. The facility has a fire alarm system with hard wired smoke detection in the basement, corridors and in spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity for 147 residents and had a census of 97 at the time of this survey. All areas accessible to residents are sprinklered. Areas providing facility services were sprinklered except a detached shed and a building used for storage. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/05/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:			

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K010018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 3 of 11 smoke compartments could latch into the door frame. This deficient practice affects staff, visitors and 40 or more residents in the 2 north, the first and second floor center smoke compartments. Findings include: Based on observation with the maintenance director on 02/28/13 between 11:30 a.m. and 2:30 p.m., the double door sets protecting openings to the corridors for the storage room near room 258, the first and second floor ice machine rooms, and two door sets to the first floor dining room each had one	K010018	**K 018** It is the practice of this provider to ensure that doors protecting corridor openings latch into the door frame. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The double door set protecting the openings to the corridors for the storage room near room 258, the first and second floor ice machine rooms and the two door sets to the first floor dining room	03/30/2013

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	inactive leaf with a manual flush bolt to secure the inactive leaf into the door frame. Unless the inactive door leaf was manually latched in these door sets, neither door was secured tightly into the door frame. The maintenance director acknowledged at the time of observations, each door could not latch automatically into the door frame. 3.1-19(b)		have been changed to automatically latch into the door frame. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. All double door sets automatically latch into the door frames. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Supervisor or his designee will check the doors monthly with the monthly fire drill to ensure they automatically latch into the frame. The Maintenance Supervisor or	

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			his designee is responsible to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The preventative maintenance log book will be reviewed related to checking doors protecting corridor openings to ensure they latch into the door frame during the monthly CQI meeting by the Interdisciplinary team. **Compliance Date: March 30, 2013**	

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K010025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure smoke barriers serving 6 of 11 smoke compartments were maintained to provide the 1/2 hour smoke resistance of the smoke barrier. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall, from a floor to a floor, from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling including interstitial spaces. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect visitors,	K010025	**K 025** It is the practice of this provider to ensure that smoke barriers are maintained to provide the 1/2 hour smoke resistance of the smoke barrier. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The 2 West smoke barrier, the 2 North smoke barrier, the 1 North smoke barrier, the 1 West smoke barrier and the dryer exhaust ducts have all been repaired to ensure the smoke barriers are maintained to provide the 1/2 hour smoke resistance of the smoke barrier.	03/30/2013

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	staff and 30 or more residents on the second floor and the 1 north, 1 west, and laundry smoke compartments. Findings include: a. Based on observations with the maintenance director on 02/28/13 between 11:05 a.m. and 11:30 a.m., the 2 west smoke barrier had two unsealed penetrations of cables with one inch gaps above the lay in ceiling. The 2 north smoke barrier had one unsealed wire/cable penetration and a second wire/cable penetration where a fire caulk seal was incomplete resulting in a two inch gap above the lay in ceiling. The maintenance director acknowledged at the time of observations, the smoke barrier was not properly sealed. b. Based on observation with the maintenance director on 02/28/13 at 1:00 p.m., the 1 north smoke barrier had a six by three inch section of drywall missing on the south side of the wall above the lay in ceiling. The maintenance director acknowledged at the time of observation, the smoke barrier was not properly sealed. c. Based on observation with the maintenance director on 02/28/13 at 1:00 p.m., the 1 west smoke barrier was incomplete above the lay in ceiling. Unrated wood studs were exposed between corridor walls on the east side of		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. The Maintenance Supervisor or his designee has examined the smoke barrier areas in the facility to ensure that smoke barriers are maintained to provide the 1/2 hour smoke resistance of the smoke barrier. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Supervisor or his designee will monitor any future contract modifications involving over the ceiling work to ensure that smoke barriers are maintained to provide the 1/2	

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	the smoke barrier above the lay in ceiling. A blackened, charred area was noted on one stud. The maintenance director said at the time of observations, the charred area was a result of "someone braised the pipe" located next to the stud. d. Based on observation with the maintenance director on 02/28/13 at 2:17 p.m., one inch gaps around two commercial dryer exhaust ducts penetrating the ceiling smoke barrier between the laundry and attic behind laundry dryers were sealed with a pink expandable foam. The maintenance director said at the time of observation, the foam was a fire resistant rated material. On 02/28/13 at 2:35 p.m., the labeling for the foam reviewed with the maintenance director read, "Fire Block Foam; Type V Residential; Danger: Extremely flammable." The maintenance director acknowledged at the time of observation and labeling review, the foam was not an appropriate material for sealing penetrations behind the gas fueled dryers. 3.1-19(b)		hour smoke resistance of the smoke barrier. The Maintenance Supervisor or his designee will review a smoke barrier area monthly with the preventative maintenance rounds to ensure that smoke barriers are maintained to provide the 1/2 hour smoke resistance of the smoke barrier. The Maintenance Supervisor or his designee is responsible to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The preventative maintenance log book will be reviewed related to ensuring smoke barriers are maintained to provide the 1/2 hour smoke resistance of the smoke barrier during the monthly CQI meeting by the Interdisciplinary team. **Compliance Date: March 30, 2013**	

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K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 12 doors to hazardous areas such as the kitchen closed automatically or upon activation of the fire alarm system. Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects visitors, staff and 30 or more residents in the first floor dining room. Findings include: Based on observation with the maintenance director on 02/28/13 at 1:00 p.m., the door separating the kitchen and first floor dining room had no means to self close and did not automatically latch into the door frame. In order for the door to latch, a dead bolt had to be turned from the kitchen side of the door. The	K010029	**K 029** It is the practice of this provider to ensure that doors to hazardous areas such as the kitchen close automatically or upon activation of the fire alarm system. It is the practice of this provider to ensure that doors to hazardous areas latch in the door frame when closed to keep the door tightly closed. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The door separating the kitchen and the first floor dining room	03/30/2013

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	maintenance director acknowledged at the time of observation, the door could not close automatically and latch into the door frame. 3.1-19(b)		closes automatically or upon activation of the fire alarm system. The door separating the kitchen and the first floor dining room latches when closed to keep the door tightly closed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. The Maintenance Supervisor or his designee has examined doors to hazardous areas to ensure they close automatically or upon activation of the fire alarm system and that they latch when closed to keep the door tightly closed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Supervisor or his designee will monitor doors to	

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			hazardous areas during monthly preventative maintenance rounds to ensure they close automatically or upon activation of the fire alarm system and that they latch when closed to keep the door tightly closed. The Maintenance Supervisor or his designee is responsible to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The preventative maintenance log book will be reviewed related to ensuring doors to hazardous areas close automatically or upon activation of the fire alarm system and that they latch when closed to keep the door tightly closed during the monthly CQI meeting by the Interdisciplinary team. **Compliance Date: March 30, 2013**	

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K010038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the accessibility for 1 of 3 doors providing delayed exit egress to the outside from the second floor. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS." This deficient practice could affect visitors, staff, and 36 residents on the second floor. Findings include: Based on observation with the maintenance director on 02/28/13 at 12:00 p.m., the emergency exit stairway door near the second floor dining room was identified by the exit sign above the door. The exit door provided access to the public way and was equipped with an electromagnetic lock which released when the door latch was pushed for 15 seconds, a code was entered into an adjacent	K010038	**K 038** It is the practice of this provider to ensure the accessibility for doors providing delayed exit egress to the outside from the second floor. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The emergency exit stairway door near the second floor dining room has a sign to notify occupants the door will open after applying pressure to the door latch for 15 seconds. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to	03/30/2013

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	keypad, or the fire alarm activated. The emergency exit door had no sign to notify occupants the door would open after applying pressure to the door latch for 15 seconds. 3.1-19(b)		be affected by the alleged deficient practice. All emergency exit stairway doors have been reviewed to ensure they have a sign to notify occupants the door will open after applying pressure to the door latch for 15 seconds. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Supervisor or his designee will review emergency exit doors monthly with the preventative maintenance rounds to ensure they have a sign to notify occupants the door will open after applying pressure to the door latch for 15 seconds. The Maintenance Supervisor or his designee is responsible to ensure compliance. **How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place? The preventative maintenance log book will be reviewed related to checking emergency exit doors to ensure they have a sign to notify occupants the door will open after applying pressure to the door latch for 15 seconds during the monthly CQI meeting by the Interdisciplinary team. **Compliance Date: March 30, 2013**	

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K010062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on observation and interview, the facility failed to ensure sprinkler piping for 1 of 1 automatic sprinkler systems was maintained free of external loads. NFPA 25, 2-2.2.2 requires sprinkler piping shall be not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice affects all occupants. Findings include: Based on observation with the maintenance director on 02/28/13 between 11:15 a.m. and 1:15 p.m., sprinkler pipes above the lay in ceilings near the 2 west, 1 west and 1 north smoke barriers had cables and wires laying over them. The maintenance director acknowledged at the time of observations, the sprinkler pipes were being used as hangers for the wires and cables. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure sprinkler	K010062	**K 062** It is the practice of this provider to ensure that sprinkler piping for the automatic sprinkler system is maintained free of external loads. It is the practice of this provider to ensure that sprinkler heads are free of paint. It is the practice of this provider to ensure shower room sprinkler heads are free of obstructions to spray patterns. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** 1.The wiring near the 2 West, 1 West and 1 North smoke barriers has been removed from the sprinkler piping. 2.The sprinkler heads protecting closets in rooms 260, 262, 147 and 155 are free of paint. 3.The shower curtains in the first and second floor shower	03/30/2013

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	heads in 2 of 11 smoke compartments were free of paint. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials such as paint. This deficient practice affects staff, visitors and 20 or more residents in the 2 west and 1 north smoke compartments. Findings include: Based on observation with the maintenance director on 02/28/13 between 11:00 a.m. and 2:15 p.m., paint was observed on sprinkler heads protecting closets in rooms 260, 262, 147, and 155. The maintenance director acknowledged at the time of observations, the sprinkler heads should not have had paint on them. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 2 of 2 shower room sprinkler heads were free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Standard for the Installation of Sprinkler Systems, in 5-5.6 requires the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice affects 30 or more residents using the first		rooms have been replaced with curtains that do not obstruct the spray pattern of the sprinklers. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. 1. The Maintenance Supervisor or his designee has examined the sprinkler pipes above the ceiling to ensure no wiring is laying on them. 2. The Maintenance Supervisor or his designee has examined all sprinkler heads to ensure they are free of paint. **3.** The Maintenance Supervisor or his designee has examined all shower rooms to ensure the curtains do not obstruct the spray pattern of the sprinklers.	

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	155152	A. BUILDING 01 B. WING	02/28/2013

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	and second floor shower rooms. Findings include: Based on observation with the maintenance director on 02/28/13 between 11:45 a.m. and 2:15 p.m., shower curtains in the first and second floor shower rooms were hung from a rod eight inches from the ceiling. The rooms were protected by a single sprinkler head which could not cover the area behind the curtain. The maintenance director acknowledged at the time of observation, the sprinkler heads were less than the minimum distance allowed between a sprinkler head and obstruction. 3.1-19(b)		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** 1.The Maintenance Supervisor or his designee will monitor any future contract modifications involving over the ceiling work to ensure that sprinkler piping is maintained free of external loads during monthly low point draining checks. 2.The Maintenance Supervisor or his designee will examine all sprinkler heads to ensure they are free of paint with the monthly preventative maintenance rounds. 3.The Maintenance Supervisor or his designee will examined shower rooms to ensure the curtains do not obstruct the spray pattern of the sprinklers with the monthly preventative maintenance rounds. The Maintenance Supervisor or his designee is responsible to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur,**	

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			i.e., what quality assurance program will be put into place? The preventative book will be reviewed related to ensuring that sprinkler piping is maintained free of external loads, sprinkler heads are free of paint, and shower room sprinkler heads are free of obstructions to spray patters during the monthly CQI meeting by the Interdisciplinary team. **Compliance Date: March 30, 2013**	

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K010064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure an annual and monthly check was provided for 1 of 1 portable fire extinguishers provided in the oxygen transfer and storage room. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. NFPA 10, 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. NFPA 10, 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. This deficient practice could affect affect visitors, staff and 10 or more residents in the adjacent corridor serving the physical therapy room and fitness center. Findings include: Based on observation with the	K010064	**K 064** It is the practice of this provider to ensure an annual and monthly check is provided for portable fire extinguishers. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The portable fire extinguisher in the oxygen transfer and storage room has been checked to ensure it will operate effectively and safely and the tag is up to date. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to	03/30/2013

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	maintenance director on 02/28/13 at 2:25 p.m., the service and inspection tag on the portable fire extinguisher in the oxygen storage and transfer room noted the last monthly check had been done 09/27/12 and the annual check done in October of 2011. The maintenance director said at the time of observation, the fire extinguisher should have been replaced by the fire extinguisher contractor in October 2012. He conceded his monthly checks had not included this fire extinguisher since September 2012. 3.1-19(b)		be affected by the alleged deficient practice. The Maintenance Supervisor or his designee has checked all portable fire extinguishers to ensure they will operate effectively and safely and the tags are up to date. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All portable fire extinguishers are checked monthly and annually to ensure they will operate effectively and safely and the tags are up to date with monthly preventative maintenance rounds. The Maintenance Supervisor or his designee is responsible to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The preventative maintenance log book will be reviewed related to	

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			ensuring fire extinguishers are checked monthly to ensure they operate effectively and safely and the tags are up to date during the monthly CQI meeting by the Interdisciplinary team. **Compliance Date: March 30, 2013**	

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K010069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96			
	Based on observation and interview, the facility failed to ensure 1 of 1 commercial cooking extinguishing systems was maintained. NFPA 96, 9.1.2.2 requires cooking appliances requiring protection shall not be moved, modified, or rearranged without prior reevaluation of the fire extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Exception: Cooking appliances moved to perform maintenance and cleaning provided the appliances are returned to their original positioning prior to cooking operations, and any disconnected fire extinguishing system nozzle attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. This deficient practice could affect 4 kitchen staff, and 20 or more visitors and residents in the adjacent first floor dining room. Findings include: Based on observation of the commercial kitchen range hood protection system with the maintenance director on 02/28/13 at 2:10 p.m., protection was not provided for the commercial gas range	K010069	**K 069** It is the practice of this provider to ensure that commercial cooking extinguishing systems are maintained. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The extinguishing system nozzles for the commercial gas range and adjacent grill are directed to protect areas of the appliances which could be the source of a fire. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged	03/30/2013

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	and adjacent grill by the hood fire protection nozzles. Three extinguishing system nozzles were in stalled at angles above, and pointed at the ten inch stainless steel shelf located above the appliance. The maintenance director said at the time of observation, a new range and grill skillet had been installed and the extinguishing nozzles replaced in this orientation. He agreed the nozzles did not appear to be directed to protect areas of the appliances which could be the source of a fire. 3.1-19(b)		deficient practice. The Maintenance Supervisor or his designee will audit the extinguishing systems nozzles with monthly preventative maintenance rounds to ensure they are directed to protect areas of the appliances which could be the source of a fire. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Supervisor or his designee will audit the extinguishing systems nozzles with monthly preventative maintenance rounds to ensure they are directed to protect areas of the appliances which could be the source of a fire. The Maintenance Supervisor or his designee is responsible to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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			The preventative maintenance log book will be reviewed related to the extinguishing system nozzles for the commercial gas range and adjacent grill to ensure they are directed to protect areas of the appliances which could be the source of a fire during the monthly CQI meeting by the Interdisciplinary team. **Compliance Date: March 30, 2013**	

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K010147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 1. Based on observation and interview, the facility failed to ensure a wet location for 1 of 76 resident rooms was provided with ground-fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect visitors, staff and 2 residents in room 158. Findings include: Based on observation with the maintenance director on 02/28/13 at 12:45 p.m., the electrical outlet in the bathroom serving resident room 158 was located 18 inches from the sink. The outlet was not provided with GFCI	K010147	**K 147** It is the practice of this provider to ensure that wet locations are provided with ground-fault circuit interrupter (GFCI) protection against electric shock. It is the practice of this provider to ensure that electrical wiring connections are maintained in a safe operating condition which includes junction boxes. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** 1.The electric outlet in the bathroom serving resident room 158 been eliminated. 2.The junction box near the 2 North smoke barrier has a cover compatible with the box. A covered junction box has been provided for the four wires near the 1 North smoke barrier. 3.Power strips are not used to power nebulizers. Power strips are not used in conjunction with	03/30/2013

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	protection to prevent electric shock. The maintenance director said at the time of observation, there was no circuit panel GFCI for the outlet and the outlet should have had GFCI protection. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 electrical wiring connections were maintained in a safe operating condition which included junction boxes. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect visitors, staff and 30 or more residents in smoke compartments protected by the 2 north and 1 north smoke barriers. Findings include: a. Based on observation with the maintenance director on 02/28/13 at 11:20 a.m., a junction box above the lay in ceiling near the 2 north smoke barrier 129 was left uncovered with multiple wires exposed. The maintenance director said at the time of observation, the box was so full it looked as though the cover would not have fit and a larger junction box was needed. b. Based on observation with the		extension cords. Extension cords are not used in the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. 1.The Maintenance Supervisor or his designee has reviewed all wet locations to ensure they have ground-fault circuit interrupter (GFCI) protection against electric shock. 2.The Maintenance Supervisor or his designee has reviewed junction boxes above the lay in the ceiling to ensure they have covers compatible with the boxes. 3.The Maintenance Supervisor or his designee routinely check rooms for extension cords and replace as needed. The nurse staff were re-inserviced to not use a power strip to power a nebulizer by March 30, 2013.	

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	maintenance director on 02/28/13 at 1:12 p.m., the connections for four wires above the lay in ceiling near the 1 north smoke barrier were made with wire nuts. No junction box was used. The maintenance director acknowledged at the time of observation the wires should have been provided with a covered box. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 5 of 5 flexible cords were not used as a substitute for fixed wiring in the 1 west and 1 north smoke compartments. NFPA 70, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect visitors, staff, and 30 or more residents in the 1 west and 1 north smoke compartments. Findings include: a. Based on observation with the maintenance director on 02/28/13 at 1:15 p.m., a power strip extension cord was used to power a nebulizer in room 161. The maintenance director said at the time of observation the practice was not permitted. b. Based on observation with the		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** 1 The Maintenance Supervisor or his designee will monitor wet locations with monthly preventative rounds to ensure they have ground-fault circuit interrupter (GFCI) protection against electric shock. 2. The Maintenance Supervisor or his designee will monitor any future contract modifications involving over the ceiling work to ensure that junction boxes above the lay in the ceiling have covers compatible with the boxes. 3. The Maintenance Supervisor or his designee routinely check rooms for extension cords and replace as needed during monthly preventative maintenance rounds. The Maintenance Supervisor or his designee is responsible to ensure compliance.	

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	maintenance director on 02/28/13 at 1:15 p.m., a power strip extension cord was piggybacked with an extension cord in room 164 to power a television and clock. The maintenance director said at the time of observation, the cord had been brought in by family members. c. Based on observation with the maintenance director on 02/28/13 at 1:25 p.m., an extension cord supplied power to Christmas tree lights in room 169 and a pink extension corn was in use in resident room 146. The maintenance director said at the time of observation, the residents had been provided with power strips, extension cords were not permitted. 3.1-19(b)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The preventative maintenance log book will be reviewed during the monthly CQI meeting by the Interdisciplinary team. **Compliance Date: March 30, 2013**	

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K020046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation and interview, the facility failed to ensure battery powered emergency light fixtures in 3 of 11 smoke compartments would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice could visitors, staff and 10 or more residents in the west center first and second floor, and the laundry smoke compartments. Findings include: Based on observation with the maintenance director on 02/28/13 between 11:00 a.m. and 2:30 p.m., battery powered emergency lights failed to illuminate when tested twice in the first floor dining room near the dietary storage closet, in the second floor corridor, and in the second floor medicine room in the corridor outside the laundry. The maintenance director said at the time of observation, he did not know the lights were not working. 3.1-19 (b)	K020046	**K 046** It is the practice of this provider to ensure that each battery operated emergency lighting fixture operates as required. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The emergency lighting fixtures in the first floor dining room near the dietary storage closet, in the second floor corridor and in the second floor medicine room in the corridor outside the laundry have been tested and the batteries have been replaced. All fixtures are working properly. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	03/30/2013

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			corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All battery operated emergency lighting fixtures have been tested to ensure they are working properly. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A monthly test of 30 seconds and an annual test of 90 minutes will be conducted on all emergency lighting fixtures with preventative maintenance rounds. Batteries will be changed routinely and no less than once a year. The Maintenance Supervisor or his designee will be responsible. **How the corrective action(s) will be monitored to ensure the**	

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MONTICELLO ASSISTED LIVING AND HEALTHCARE	1120 N MAIN ST MONTICELLO, IN 47960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			deficient practice will not recur, i.e., what quality assurance program will be put into place? The preventative maintenance log book will be reviewed related to ensuring all emergency lighting fixtures are working properly during the monthly CQI meeting by the Interdisciplinary team. **Compliance Date: March 30, 2013**	